A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Doctors of Chiropractic

Provider Class Plan

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PROVIDER CLASS

A provider class may include health care facilities or health care professionals who have a reimbursement arrangement or participating agreement with Blue Cross Blue Shield of Michigan to render services to BCBSM's members.

Definition

The doctors of chiropractic medicine provider class is composed of DCs licensed in Michigan.

Covered Services

BCBSM reimburses DCs for the following medically necessary services when they are benefits under the member's benefit plan:

- spinal chiropractic manipulative treatment
- evaluative and management services
- radiologic services to diagnose and treat conditions of the spine and contiguous tissues when the condition is due to spinal misalignment or subluxation
- emergency treatment of an acute spinal condition, and
- mechanical traction when performed with chiropractic manipulative treatment.

PA 350 GOALS AND OBJECTIVES

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the two calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the four calendar years immediately preceding the year in which the commissioner's determination is being made.

Objectives

1. Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.

2. Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement.

3. Make a good faith effort to enforce the per-claim participation provision in Section 502(1)(b) of PA 350 by responding to all inquiries and complaints.

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objectives

1. Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.
2. Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participation agreement and its administration.
3. Maintain and periodically update a printed or Web site directory of participating providers.

Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

1. Ensure that BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualifications and performance standards.
2. Meet with the Physician and Professional Provider Contract Advisory Committee on an ongoing basis.
3. Meet with specialty liaison societies to discuss issues of interest and concern.
4. Evaluate practice patterns with the retrospective profiling program and make the results available annually to providers.
5. Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes and disputes regarding utilization review audits.

BCBSM POLICIES AND PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that affects its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

Participation Policy

Michigan DCs may choose to participate on either a formal or per-claim basis. Their participation agreement requires them to do many things, such as meet BCBSM's qualification standards, abide by BCBSM policies and accept BCBSM's payment as payment in full for all covered services, except for copayments and deductibles identified in members' certificates.

DCs participating on a per-claim basis must accept BCBSM's payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year". [PA 350, Section 502(1)(b)]. In addition, DCs participating on a per-claim basis will be bound by the terms and conditions of the Physician and Professional Provider Participation Agreement with respect to the claims on which they participate per-claim. DCs participating on a per-claim basis must also meet standards of professional performance that apply to formally-participating DCs.

Covered services rendered by DCs who do not participate, either formally or on a per-claim basis, are payable to the member.

Qualification Standards

BCBSM offers all qualified DCs the opportunity to participate. Standards for either formal or per-claim participation may include, but are not limited to:

- A current Michigan license* as a doctor of chiropractic medicine

* BCBSM verifies licensure regularly with the state of Michigan.

- Absence of inappropriate utilization/medical necessity practices as identified through proven member complaints, medical necessity audits and peer review

- Absence of fraud and illegal activities

BCBSM may deny participation to DCs who do not meet or maintain these qualification standards.

Departicipation Policy

A departicipation policy allows BCBSM to departicipate a provider after review and recommendation for departicipation by the BCBSM Audit and Investigations Subcommittee. This policy is further described in Addendum I of the attached Physician and Professional Provider Participation Agreement.

Member Sanctions

BCBSM will not apply any sanction to subscribers receiving services from departicipated providers unless it is authorized to do so by an amendment to PA 350 or other appropriate authority.

Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs.

Communications and Education

BCBSM provides the following resources to communicate with and educate DCs:

- The Physician and Professional Provider Contract Advisory Council is committed to providing ongoing support to the physician community. The committee meets on an ongoing basis to offer advice and consultation on topics such as: proposed modifications to the contract; administrative issues which may arise under the contract; medical necessity criteria and guidelines; reimbursement issues; experimental or investigational procedures; and physician supervision of services.

- *The Record* and *Physician Update,* monthly BCBSM publications that communicate current information regarding billing guidelines, policy changes and other administrative issues

- A manual which provides information on how to do business with BCBSM explains billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and the Physician and Professional Provider Participation Agreement and its administration. BCBSM maintains and updates this manual as necessary.

- A physician directory and the BCBSM Web site which include current lists of participating DCs

- Continuing medical education seminars

- The liaison process which provides a forum in which specialty societies can bring issues of concern to BCBSM's attention. The process can include meetings with specialty societies as well as contact with BCBSM representatives by telephone or email.

Performance Monitoring

- Physician Retrospective Profiles evaluate provider utilization practice patterns. Profiles are made available each year to providers upon request.

- BCBSM's provider credentialling process which uses an electronic data transfer from the Michigan Department of Labor & Economic Growth, ensures that physicians maintain current state of Michigan licensure

- Utilization review audits serve as a check and balance to ensure that services were medically necessary and paid within the scope of members' benefits.

- Suspected fraudulent activity, reported to BCBSM by providers, members, or BCBSM staff, is referred to Corporate Financial Investigations for further investigation. If fraud or illegal activities are confirmed, BCBSM will report such providers to the Michigan Department of Labor & Economic Growth.

Appeals Process

BCBSM has an appeals process that allows the physician or professional provider the right to appeal adverse claim decisions involving non-policy or policy issues. The specifics of this process are described in Addendum E of the Physician and Professional Provider Participation Agreement. The three-step process includes:

1. Submitting a written complaint
2. Requesting an informal conference
3. Selecting one of the following independent third party determination methods:

- Binding arbitration (non-policy only)
- Commissioner of Financial and Insurance Services review
- Judicial review

There is also a two-step process for a physician or professional provider who has an issue, question or concern about policy not specific to a claim. The steps include:

1. Submitting a written issue, question or concern
2. Requesting review by BCBSM's medical director if the provider is dissatisfied with the issue, question or concern response

Reimbursement Policies

Reimbursement Methods

BCBSM reimburses participating DCs for covered services that BCBSM deems medically necessary as described in the attached participation agreement. DCs are reimbursed the lower of the billed charge or the maximum payment level published in BCBSM's Maximum Payment Schedule.

BILLED CHARGE

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

MAXIMUM PAYMENT LEVEL

Most of the Maximum Payment Schedule is based on the Resource Based Relative Value System developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Maximum payment levels for all DC procedures currently reimbursed by BCBSM are based on RBRVS. If, at any time, BCBSM agrees to reimburse DCs for a procedure for which there is no Relative Value Unit, other factors may be used in setting maximum payment levels such as comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level.

BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary. In addition, BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

An alternative reimbursement arrangement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program increases reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates are low.

Covered Services

BCBSM reimburses DCs for the following services:

- spinal chiropractic manipulative treatment
- evaluative and management services
- radiologic services to diagnose and treat conditions of the spine and contiguous tissues when the condition is due to spinal misalignment or subluxation
- emergency treatment of an acute spinal condition, and
- mechanical traction when performed with chiropractic manipulative treatment.

Payment for all services is based on medical necessity, which means that physicians on behalf of BCBSM determine that the following guidelines were met: the service is accepted as necessary and appropriate for the patient's condition and is not for the convenience of the member or physician. In the case of diagnostic testing, the tests are essential to and used in the diagnosis and/or management of the patient's condition.

Member Hold Harmless Provisions

Participating DCs agree to accept BCBSM's payment as payment in full for covered services. Member copayments and deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. As outlined in Addendum F of the Physician and Professional Provider Participation Agreement, participating DCs must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental or investigational unless the member agrees in writing to pay for the services before they are provided
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame

PHYSICIAN AND PROFESSIONAL PROVIDER PARTICIPATION AGREEMENT (Attached)